Hoop #14

Tuesday, August 20, 2002
Nancy Dufault placed on administrative leave pending investigation of narcotic discrepancies.

Tuesday, August 27, 2002 10:00 a.m.
Meeting – Mary Brown, Director of Med/Surg Nursing, Jean D'Espinosa, RN, Nurse Manager, Nancy Dufault RN, ICU, Mona Karkut, RN, OR, MNA Representative

Mary Brown explained the purpose of the meeting. Review discrepancies between omnicell controlled substance report and medical record documentation. Meeting to give Nancy Dufault an opportunity to explain findings.

Report used: Omnicell Transaction by User
User Name: Nancy Dufault. Date range of report 4/1/02 12 a.m. through 8/21/02 12 Noon.
Five (5) cases were presented to Nancy Dufault.

1. Omnicell Report
   6/19/02 6:28 p.m. 2 each Lorazepam 20 mg/10ml R , P
   6/19/02 6:28 p.m. 10 each Lorazepam 20 mg/10ml R , P
   6/19/02 6:28 p.m. 4 each Lorazepam 20 mg/10ml R , P
   Total of 320 mg of Lorazepam withdrawn by Nancy Dufault,
   ICU Flowsheet 6/19/02 to 6/21/02 – P R shows patient receiving 25 mg/hr – documented by Nancy Dufault.
   IV administration record 6/19/02, 6/20/02 – no documentation of IV ativan.
   Issues: Lack of documentation in patient's medication record.
   Mixing of additional IV solutions in advance – question of controlled substance
   Loss of revenue due to pharmacy charges from medication record.
   Explanation by Nancy Dufault: "I gave the drug – just didn't chart it"

2. Omnicell Report
   7/15/02 11:51 p.m. 1 each Lorazepam 2mg B , B
   7/16/02 12:19 a.m. 1 each Morphine Sulfate 4 mg B , B
   withdrawn by Nancy Dufault
   7/15/02 10:01 p.m. 1 each Lorazepam 2 mg B , B
   7/16/02 12:52 a.m. 2 each Lorazepam 2 mg B , B
   withdrawn by Tawnia Iwasinski

   Issue: Tawnia was on orientation working with Nancy Dufault (preceptor). Tawnia documented the medications she had removed from the omnicell. No documentation of medications withdrawn by Nancy.
   Response: Nancy stated, medications were given; it was "equal to the dose ordered." Nancy thought the orientee would chart.

   Omnicell Report
   7/17/02 7:42 p.m. 1 each Lorazepam 2 mg B , B
   withdrawn by Nancy Dufault.
   7/17/02 8:12 p.m. 2 each Lorazepam 2 mg B , B
   7/17/02 8:34 p.m. 1 each Morphine 4 mg B , B
   withdrawn by Michelle Lund (assigned to the patient)
   IV administration record shows medications withdrawn by Michelle Lund are charted.
   Medication withdrawn by Nancy Dufault is not charted in the record or on the flowsheet.

Issue: was the medication administered? If it was administered – physician order was for Lorazepam 2 – 4 mg q 2 hours prn - patient would have received 6 mg within 30 minutes.
Response: Nancy stated, "have no answer for that."

3. Omnicell Report
   7/17/02 3:46 a.m. 2 each Lorazepam 2 mg B , B
   7/17/02 4:03 a.m. 1 each Morphine 4 mg B , B
   withdrawn by Tawnia Iwasinski (orientee working with Nancy Dufault).
   7/17/02 4:26 a.m. 2 each Lorazepam 2mg B B
   7/17/02 4:26 a.m. 1 each Morphine 4 mg B , B
   withdrawn by Nancy Dufault.

Issue: Medication administration record shows documentation of medications by Tawnia Iwasinski. No documentation of medications withdrawn by Nancy Dufault.
Response: Nancy states, "I guess I didn't chart it....bad documentation on my part."

4. Omnicell Report
   6/21/02 2:25 a.m. 3 each Lorazepam 2 mg R , P
   6/21/02 2:26 a.m. 3 each Lorazepam 2 mg R , P
   6/21/02 2:27 a.m. 3 each Lorazepam 2 mg R , P
   Total of 18 mg Lorazepam withdrawn in 3 minutes by Nancy Dufault.

   IV administration record 6/ 20/02 and 6/21/02 shows:
   Lorazepam (no dose noted) administered 2000 (8 p.m.)
   Lorazepam (no dose noted) administered 0001 (12:01 a.m.)
   Lorazepam (no dose noted) administered 0430 (4:30 a.m.)

Issue: How could Lorazepam have been administered to the patient at 8 p.m. and 12 Midnight if it was not removed until 2:30 a.m.?
Response: Nancy – "I bolused through the IV drip...used '999' to bolus at 8, 12 and 4:30...then used the 18mg to replace the IV".

5. Omnicell Report
   5/21/02 8:09 p.m. 1 each Lorazepam 2 mg G , M
   5/22/02 11:42 p.m. 1 each Lorazepam 2 mg G , M
   5/23/02 9:53 p.m. 1 each Lorazepam 2 mg G , M
   5/29/02 11:26 p.m. 1 each Lorazepam 2 mg G , M
   5/30/02 11:25 p.m. 1 each Lorazepam 2 mg G , M

Issue: Order was for 1 mg. Wasted Lorazepam not witnessed by second RN in all cases.
Response: Nancy, "I guess I need to get better about checking my 'waste'."

Mary Brown RN
Mary Brown, RN
Director of Medical/Surgical Nursing

Jean D'Espinosa RN
Jean D'Espinosa, RN
Nurse Manager ICU/CCU/IMC

Rose Garvey Room
Present: Mary Brown, Jean D'Espinosa, Nancy Dufault, Dave Powers and Anne Marie Smith.

Conversation began at 11:00 a.m. on August 29th.

Mary Brown: "We received several scenarios and found discrepancies between the Omnicell and the MAR". "We discussed these with you and identified different types. From that meeting some remain unclear."

Scenario # 1:

Mary Brown: "The one I presented that was most concerning was regarding P R. In this case you took Ativan out of the omnicell at 2:25 a.m., 2:26 a.m. and 2:27 a.m. Each time you took out three (3) amps of 2 mg each totaling 18 mg within 2 minutes. You charted these drugs at 8p.m., 12 a.m., and 4 a.m. Do you remember?

Nancy Dufault: "Yes I remember."

Mary Brown: "You went on to tell us this was possible because what you had done was given 6 mg boluses through the IV drip of Ativan that was infusing at the documented times. You then went to Omnicell @ 2:25 a.m. to retrieve the Ativan so you could return the drug to the IV bag that was infusing. Is this right?"

Nancy Dufault: "Absolutely, that is what I said. I specifically remember that night and doing that."

Mary Brown: "Well the problem is this cannot be true. The Ativan drip had been discontinued that morning; there was no drip when you came on."

Nancy Dufault: After much thought – "I have no answer, I cannot recall that", "I really think that is what I did."

Scenario #2:

Mary Brown: "Another incident is regarding Morphine – where you removed it later and charted it earlier.

1. On May 4, 2002 – R V
   "You removed 4 morphine @ 6:20 a.m. and the documentation shows you gave it at 2:00 a.m. There is no other morphine removed for that patient that can account for it."

2. On May 7th – R V
   "You took out 4 mg of morphine at 1:14 a.m. per omnicell reports. You then charted the dose at 12:02 a.m."
   "Again, same patient – you took out morphine 4 mg:
   a. at 3:23 a.m. and documented it @ 2:00 a.m
   b. at 4:39 a.m. and documented it @ 4:00 a.m.

Mary Brown: "Numerous times this occurs where the documentation is earlier than the drug was removed from omnicell. You are also not documenting the dose you give."

Nancy Dufault: "Those times I charted it later; I just probably charted it wrong on SMS."

Scenario #3:
Mary Brown: The following are all on Isgro. You took out on May 14th the following:

1. 11:41 p.m. – 2 mg morphine – not charted at all.
2. 1:39 a.m. – 4 mg morphine – not charted at all.
3. 1:46 a.m. – 10 mg morphine – not charted at all.

"The question is why did you take out so much morphine and not chart them. Also, this patient did not even have this amount order."

Nancy Dufault: "Well, I cannot explain this – my documentation must be off – I'll get better."

Mary Brown: "Nancy, it is more than documentation, we have listed quite a variety of discrepancies which you do not have an answer for."

Jean D'Espinosa, RN
Nurse Manager ICU/CCU/IMC

JD/am